KanCare Overview for Providers
Total Run Time: 36:17

So, let me start off by rewinding to last year and tell you a little bit about our current Medicaid program and the challenges we have with it.

When Governor Brownback took office in January 2011, with our Medicaid program we were facing a $200 million budget deficit. So, instead of automatically reducing rates and restricting eligibility, restricting choice, cutting services, what Kansas has done in the past, or what other states have done, we decided, he decided to transfer $200 million plus from the bank of the Department of Transportation and that gave us a chance to take a more long term view and evaluate our Medicaid program and where we want to go with it.

What we found when we started studying it, our first concern was the spending and the cost, which caused the deficit in the first place. And we were finding that the number of people that we served were rising four and half to five percent every year and that had been pretty consistent between 2000 and 2012, to where we're now serving 383,000 Kansans and the total spending for the program had risen seven and a half percent a year to where it's now a $3 billion program. And that had also been pretty consistent over a 12-year period from 2000 to 2012. We take a look at that. And we take a look at what we believe, what we know is the aging system with the way the demographics are shifting we look at our home and community based services, we look at our waivers and our various programs, it is an aging system that's become more and more complex with more and more chronic conditions and needs and that certainly plays into those costs and what needs to happen in the future.

We also looked at what's happening at the federal level and I think most would reasonably believe that the level of spending that we currently have with either Medicaid or Medicare can't be sustained. And even the most conservative estimates that we've seen over the next eight or 10 years, Kansas will be seeing hundreds of millions of cuts to our Medicaid program from the federal level, even through a variety of mechanisms most likely through reducing the federal Medicaid percentage maximum we currently get from the federal government.

So, spending was the first reason, the primary reason we started taking a look at Medicaid. The second is just as important, more important, which was the outcomes of the Kansans that we serve through Medicaid. Right now, we have a very volume-based system where we're contracting with thousands of providers every day. And we're paying based on volume of who those providers are serving. Many of those systems we're not necessarily paying for how well we take care of all those persons' needs. We also find that we have a very fragmented system with not as much accountability.

With the 383,000 served, that's broken into three categories. You'll see those up on the screen. Although those numbers don't quite add up if you look on the left side of the column and add the three. This is from 2010. And that has grown. We now serve 383,000. So the three groups are children, families and pregnant women. We serve a majority of our caseload on Medicaid through this group. It does have the smallest costs between the three. Some of the key concerns that were noted when we went off last year were that this is a very mobile population and often move in and out of eligibility and in and out of HealthWave program.

The second group are older adults. And we serve approximately 40,000 through either providing services through nursing homes on Medicaid or home and community based service program for the elderly or just those that are in need of those but receive acute primary care copays through Medicaid. The third group are persons with disabilities. The many waivers that we provide management and oversight for, as well as the intellectually disabled, behavioral mental health services and the substance abuse services.

So, what we were asked to do last year, was travel around the state and talk to as many people as possible from consumers, providers, advocates, members, beneficiaries, associations, so forth. I won't go in detail what's up on the screen or what you may have heard before, but we did go around the state and had dozens of meetings and a couple of large public forums and many of the ideas which we received, 2,800 different ideas as we went around the state. Many of those were incorporated into our KanCare initiative. We broke those themes into four different categories, each you see up on the screen on the left side. The first is the need for integrated whole person care the second is to creating a path to independence. The third is the need for alternative access models and the fourth is the need for enhanced, community-based services.

We translated those to the goals, the state of Kansas goals you see on the right side of the screen. From improved health outcomes, bending the cost curve down over time through our spending, not having eligibility cuts, provider cuts, service cuts, as options in the program, and then also addressing stakeholder key themes.

So, our solution has not been to, and we took this off the table early to reduce provider rates, cut services or limit provider choice. Our solution instead is a program called KanCare. So, within KanCare that will begin in 2013, there are four major changes that will be occurring. You see those up on the screen. The first is person-centered care coordination. The second is clear accountability. The third is improved outcomes. And the fourth is consolidation of our financing system. So the first change, that's really the most important is that we take off the easing options with cutting spending, which are reducing, cutting rates by say what happened in 2010 by 10 percent, restricting eligibility, cutting services. When you take those off the table what you're left with is providing better care, better services and having better outcomes.

There are a number of services that will be added to the Medicaid system through KanCare. These will be services that will not be offered on Dec. 31 but will be offered with KanCare on Jan. 1, 2013. And we believe things that will help with health promotion preventative type care, wellness type benefits that are needed to keep persons home, independent, healthy, with chronic conditions as long as possible. You see a few of those things up on the screen. Heart and lung transplants for adults, bariatric surgery. And the third you see there, there are a number of what we call value added services that will be offered. All of the organizations that bid on the KanCare system, we asked them what are things that you propose offering to your members or beneficiaries that will be at no additional cost to the state that would add preventative wellness health promotion type services.

So, there are a number of those type things, some of them are common between the three companies—Amerigroup, United, and Sunflower—that we are contracted with. And then there are some that are specific to one or two plans. Some of the benefits that are common between the three are adult preventative dental that's not offered now. There are a number of wellness type benefits, a variation between the three plans, such as offering smoking cessation…breaks or after the presentation today, the different services that will be offered by each of the three whether that be, some of them are

offering telemedicine, telehealth services, transportation, respite care-type services. As we looked at those, at least I thought, how they were innovative and brought a lot of value to KanCare.

The next thing you see up on the screen, is a concept called health homes. This is one of our primary ways that we plan to save money, reducing costs, the growth of costs and to achieve person-centered care coordination. So, again, if you take off the table, service benefit cuts, reductions, reimbursement rate reductions and limiting provider choice or state providers in the network services, what you're left with, I apologize for sounding repetitive, is provide better care.

I think that we for most of us in this room, we can think of personal examples either a loved one or someone you provide care and services for or organization that live within a very fragmented type health care system. What I mean by that, I'll give an example of one of my family members that lived in another state, on a Medicaid program similar to ours as of today, on a fee for service model. This family member of mine had a primary care physician. He had a diabetes specialist, he had a liver specialist, he had a mental and behavioral health counselor. He had seven different providers, specialty physician providers, counselors and also comparable to our Home and Community Based Services system here in Kansas. Seven different organizations that were providing care and services to him, and often they were not talking to each other. The primary care physician was not talking to or communicating with the diabetes specialist. And the attending care workers from the HCBS system were not plugged into the system of what they should have been looking for for the diabetes. The same for the behavioral mental health counselors and so forth. You have a real fragmented type system. Not any one entity organization looking after the care of him, all of his needs. They were all segmented out in this fragmented system. And as a result, he bounced in and out of the hospital emergency room 29 times in the last year and half of his life before he passed away. That's a pretty generalization of a case, a pretty extreme example. I can think of dozens of other cases similar to that of older adults or persons with disabilities I've served in my organizations and over the years and others that we've come in contact with over the last year and a half or two. If we do a better job coordinating the care and needs of the entire person, and not having such a silo fragmented type system we'll be much better off with how we're serving you through Medicaid.

So, health homes are one of the primary ways we intend to do that. One of the primary things through this is that every person will be assigned a care coordinator and that care coordinator is different from what many of you may employ or see through a community based service case manager. Where the HCBS case manager is often primarily set up to help coordinate and plug in attended care, housekeeping, transportation, the long term social supports. The care coordinator will responsible for coordinating all the person's needs, from physical, medical, behavioral and mental health, diabetes if the person has that and all the other services. Health homes is the concept of that care coordination tool. There are six different components of health homes. A number of states have started doing this. We've had eight or 10 different pilots with mental health centers and federally qualified health clinics over the last couple of years that have been very successful. And then we've also had a number of pilots with primary care clinics that have been a little bit of a spin off these health homes with medical home that are very similar. They've also had a lot of success. So, the general concept behind these health homes is more resources and communication you have surrounding the person's care, linking together all these different systems, if a person comes home from the hospital to make sure they know what medications they're supposed to be taking, to know that they're going to make the next doctor's appointment that's coming up in the next couple of days instead of two months, they have services and resources they need to stay healthy, happy with good outcomes as long as possible.

There will be six components for these health homes. Three of them are clinical/medical related. Three of them are more long term services/supports related. Within KanCare, I know the first year, our intent is to have any person that has a mental health need diagnosis and/or diabetes or both, will be within one of these health homes with this care coordination tool by the end of the year. And then, by the end of the second year, anyone who has a complex need or condition will be within a care coordination type model with these health homes.

The next thing you see up on the screen is options counseling. We're in the process of setting up, the procurement process, of aging and disability resource centers or ADRCs for short. These are intended to be one stop shops for information and assistance and also what we call options counseling, particularly for those we serve, our older adults, frail elderly, nursing homes, traumatic brain injury and physical disability waivers. The primary difference between these and some of the current systems we have set up are these ADRCs will complete the functional eligibility assessment for those three populations and also provide options counseling to help their family and the person served, determine which of the three plans is best for them, be able to differentiate between the three and help them make that choice. And then they will not be able to be in the provider network so provide services, case management whatever it may be for any of the three plans.

Moving on to the next slide, the second major change we outline is clearer accountability. So, as we look to go to more of a performance based outcome system, we clearly need data and outcome measurements to make that happen. So, you'll see up there we have required, will require each of the three companies contractors to have health information systems, to report data to us and also to our federal partner CMS. And we'll also be using an external group quality reviewer, Kansas Foundation for Medical Care. We have a number of performance measurements built into KanCare that we will be measuring. I'll cover more of that here in a minute.

The third major change is improved outcomes. Through health homes and the care coordination tool, through some of the ARDC type model, elimination of conflict of interest, through some of the system reforms we have we are expecting improvement in outcomes for those we serve. You'll see some of those things up on the screen what we're looking for and what we think we have a great opportunity for improvement for. And those are keeping people at home longer, decreasing re-hospitalization avoidable admissions, managing chronic conditions better than we do now and also, improving access to health services.

Part of our reform team within the administration, our two positions, and Dr. Moser and Dr. Colyer, and they give examples often, particularly Dr. Moser, in his practice in Greeley county in western Kansas, which is about as far west as you can get without being in Colorado. Trying to track down providers and access for the clients he serves in the 25 years he's served as a physician, and this is one of the things we believe KanCare will bring to the table is a statewide network and the power of the networks to where that care coordinator will help line some of those things up as compared to how the system works now.

And the fourth change, that's consolidating our financing system. And we will be moving to see the entirety of our Medicaid system a risk based capitated system. This is going away from what we call fee-for-service volume-based system where we're paying based on x number of people you are serving to we are paying the three companies Amerigroup, Sunflower and United a set capitated amount per month. And they are fully responsible to take care of, contract out for all those person's needs. With the incentives that will be in place for better outcomes, you'll see that we've encouraged incentivized

coordinating each individual's care with providers through financing and decreasing everything we just mentioned.

We will be rewarding contractors in the system for paying for preventative care to keep persons healthy. Whereas with the current system where preventative health promotion funding and activities tend to be one of the first things that gets cut at the state level.

Moving on to more of the specifics, in order for us to move to this kancare model we are seeking what's called an 1115 waiver from the federal government. It's from CMS, Center for Medicaid/Medicare Services. There are four different things we are requesting through this 1115 waiver. You see those up on the screen. The first is to move all of the Medicaid populations to managed care through mandatory enrollment. Right now, the 383,000 that we serve, 73 percent are already within a managed care setting or environment. Those are mental health systems through Kansas Health Solutions, our substance abuse system, through value options, our Health Wave programs, CHIP through Unicare and Children's Mercy. So, those are our four different contractors we use now with mandatory enrollment. They'll move to the three managed care contractors we'll be working with and there will be more choice built into this for them for those who have a use for managed care environment over the last number of years.

The second thing that you see, we will be covering all Medicaid services through this KanCare system. So, the remaining 27 percent that are not in the managed care system now are primarily Home and Community Based Services waivers, nursing homes, members will be rolled into the managed care system.

The third thing that we're seeking is to establish what are called safety net care pools for hospitals. This is not all that much different from what we do with hospitals now that we're working with and their associations on this if the community needs it moving in that direction through the managed care system.

The fourth waiver asks for us to go to pre-enroll members into the managed care plan. So, what we are asking for is to have 45 days prior to Jan. 1, 45 days following Jan. 1, for all the Medicaid we serve to switch plans.

There are a number of formulas that will be worked on that will be used to assign members to one of the three plans. An example of that formula would be who the primary care physician is. And if that physician is signed up for one plan and not the other two, then that formula, algorithem would automatically enroll that member into the plan with that primary care physician. Or if their primary care provider is a long term services support provider, they would be in that plan. A second formula would then, if there were differences between would be to enroll that person if they have a family member or sibling, spouse, brother or sister, the intent is to try and get them into the same plan. There will be a number of formulas that will trigger auto assignment or auto enrollment as we call it, in the first part of November of this year. But then there will be between then and the end of the year for them to choose one of the other two plans that fits them better.

And then following KanCare going live Jan. 1, 2013, everyone will still have 45 days until Feb. 14 of next year, to change their plan.

On to the next slide, one of the desired goals that we have has already been stated, is to utilize home and community based services more than we do now and to keep people whether they be older adults

or persons with disabilities at home as long as possible. We think we have a great opportunity to do this. Some of the numbers and the matrix that we have looked at, is that Kansas has the fifth highest percentage of older adults living in nursing homes in the country per capita. That is 5.2 percent of those over 65 compared to the national average of 3.8 percent. There's really no pattern as to what we may expect around the state in rural versus urban areas. Among our 105 counties, we have a utilization that is above what the national average is. Even though such as Topeka and Shawnee county we have infrastructure, transportation and housing for the most part, adult daycare and other options, utilization is still twice what the national average is. So, our financing mechanisms for HCBS are aligning. My prior is experience in running a similar organization is yes, there is a percentage that could be living in a less restrictive, less costly setting. It could be assisted living community. It could be living at home with services. By independent or assessment that we look at on a quarterly basis, 18.6 percent of our 10,000 persons that we have living in nursing homes on Medicaid, could be living in a more independent type environment.

The one thing that is of note, is our system, even with saying that, our system is not linking up together in that the two Home and Community Based Services programs that we have, that are primarily intended to keep persons out of nursing homes which are the Home and Community Based Services Frail Elderly Waiver and the Physically Disabled Waiver, which between the two of them serve 13,000 persons. That house the four types utilization in the country that we run out of state. So, virtually no other state has as high of utilization and spending on those two waivers and also has such a high utilization on what we do in nursing homes. So, we put in a number of performance, pay for performance measures, incentives requirements, even on some of our reimbursement mechanisms within KanCare's three companies will utilize and incentivize Home and Community Based Services particularly for persons with disabilities and older adults.

That's not to say that nursing homes are the problem. Because they are not. They're valued members of our network and state. They will certainly be part of the solution as we move forward.

Moving on from there, on the next slide, we do intend to maintain the consumer voice that we have in our current Medicaid system available today. We made a very effort to go around the state last year and gather as much feedback and input as possible about what changes we could make. And many things with reforms, health homes or ADRCs or the waiver, plugging in conflict free case management or many of the things that developed are where KanCare came from hearing from providers and consumers last year. We want that to continue. We have developed and started a Governor's KanCare advisory council that began meeting in March. It has met a couple of times since then. We also have four stakeholder implementation groups that are responsible with helping us with quite a few of the implementation details as we move forward between now and January. We want to take care of the major things that could go wrong or (inaudible) so the rollout is as seamless as possible.

You can go to the KDHE.ks.gov website to find a listing of those four workgroups that we have set up with providers and consumers and advocates. And uh, find out who are on those and you'll be able to plug into those members. Those four groups are how you get to 18 internal implementation work groups we have with state staff. We are very vested right now on insuring a smooth implementation of KanCare.

Each of the three organizations that we are contracted with Amerigroup, Sunflower and United, have required and would have anyway a member advisory committee, within each of their three

organizations and plans. And I'm sure if you want to see who's serving on that you could get with them out in the lobby.

As I said earlier, one of the main focuses of KanCare is improving health outcomes. We believe KanCare provides us really with the first set of goals and targeted results for our Medicaid system—that's compared to what we have now. This will put us on a path to improvement and efficiencies. We have clearly provided performance expectations and penalties if expectations are not met. So we want historical, easy alternatives to cutting the rates of services and providers.

One of the key components of KanCare are what we call pay-for-performance measures, in order to achieve improved outcomes. And this is a deal where we are withholding three to five percent of the annual amount we pay to the three companies until they demonstrate to us how many pay-per-performance measures they have met. In year one of 2013 of KanCare, we will be measuring six different items. And these are more process and operational items, such as how quick will you provide a payment or pay a provider plan for pay, how well the plans are doing with responding to grievances from providers and members, so those kinds of operational details that we need to get this up and going smoothly.

During that time, we'll be collecting targeted collected data for benchmarks for years two and three and you will have 15 pay-for-performance measures for the second and third year of the contracts. Of those 15, there are five that are more physical health related. Some examples of those are diabetes care, follow-up, one of them is how well you do with well child visits for the first months after birth. There are a number of what are called measures that we link to the physical health. I believe that stands for health improvement data information set. It's a fairly standard national benchmark for those types of measures.

Then there are five behavioral health measures that we've plugged into those pay-for-performance measures. Also, five long term services and supports pay-for-performance measures that relate to things such as re-hospitalization, utilization of nursing homes, customer satisfaction, and those kinds of things. If you are interested in finding more about these performance measures, you can go to the kdhe.ks.gov website and go to the contract with the RFP. Instead of reading through the whole thing, which you could do, but if you want to read about these quality measures, if you go to attachment J, which is the state quality strategy, and that is an 88 page document. Even that 88 pages is lengthy, but it does have a table of contents where you can skip through to whatever your particular interest is.

A few more particulars and then I'll wrap up. One of the things that we heard as we've been around the state the last year, is of course, how important timely claims payment is to providers. So, that is one of the things that we have included in the year one of the pay-for-performance measure. And one of the things that we will be measuring very closely.

A couple of slides about pharmacy. The three companies do have pharmacy benefit managers or PBMs. For Amerigroup it is CVS or Caremark. For Sunflower, that's U.S. Script. And for United, it's OptumRX. That does not necessarily mean the pharmacy provider is that's who is there benefit manager. So, I had someone in Topeka on Monday, come up to me after the presentation and said, "does that mean CVS is going to be coming to Seneca, Kansas?" No, that's not the case. These three companies are who the three organizations are using for PBMs.

On the next slide, the state will have one, what's called PDL—preferred drug list. Some of you are more familiar with this than others. The state Medicaid system currently has a PDL that will translate into the new system of KanCare. They are also required to have auto prior authorizations within the system to minimize paperwork and phone calls. One of the things we've included is mail order and specialty pharmacy options. They may be offered but are not allowed to be made mandatory.

The state will have a centralized pharmacy provider website that will serve as a hub for links to each of the MCOs information, forms, etc. Also, providers will have the opportunity medication management services to the people we serve.

The three companies have agreed to the state's dispensing fee $3.40 per claim and have also agreed to the language regarding MAC pricing, which is the maximum allowable cost. So, for pharmacy.

Lastly, one of the things which is a major change that we list earlier is the change or realignment of the state agencies. One of the things that we again heard last year during our feedback forums were people asking us, providers asking us to look at how we could streamline the interaction we provide with state agencies. We have a number of providers, many of you in this room provide services to multiple Home and Community Based Services waivers that will be split between agencies where you may provide services for those who have Medicaid and Medicare benefits, which is split between multiple agencies. And then we also talked to several other states that have gone to somewhat similar type systems to KanCare that encouraged us to think about how we are aligned. As a result of those conversations, we have gone from a year and a half ago, we had four agencies responsible for dealing with Medicaid to now only two. Those agencies are as of July 1, a month ago, the Department for Aging and Disability Services and we serve the traditional aging programs—Older Americans Act, nutrition programs. We work with Area Agencies on Aging, nursing home reimbursement, nursing homes, adult care homes, inspection, regulatory type processes. Then we have combined or merged with disability programs that were at SRS. All of the Home and Community Based Services waivers, the behavioral health services, the oversight of five state hospitals/institutions. They all form one new agency. Also, one minor part of KDHE, health occupations credentialing is part of that for long term services and functions. We are responsible for the program functions, working with stakeholders for all those programs under Medicaid.

The Department for Health and Environment, particularly the Department for Health Care Financing, KDHCO will be responsible. The second agency responsible for Medicaid and will be central to KanCare oversight financing and organizing at the state level.

The third, SRS is now named as of a month ago, the Department for Children and Families. It's primarily responsible for non-Medicaid children and families programs.

With that, I'll turn it back over to Gary. Thank you all for your attention this afternoon. And I hope this will be of help to you.